Facility: ____

North Carolina Division of State Operated Healthcare Facilities
Continuing Care Plan (CCP) for Community Follow-Up/Discharge Summary

Addressograph

Patient's Name: ______________________________ MRUN: _______________________

Admitting LME/MCO: _______________________________ Code: _ County_____________

Discharge LME/MCO: _______________________________ Code: _ County_____________

Responsible LME/MCO _______________________________ Code: ______ County ________________

Outpatient Appointments: Consent Signed

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose of Appointment:			

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose of Appointment:			

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose of Appointment:			

☐ Check box for Homeless (per Homeless policy) **Fax copy of CCP to DSOHF at 919-508-0955:**

Give patient a completed copy of this form prior to discharge and also fax form to LME/MCO.

( ) Info faxed to LME/MCO on (Date) ________________by_____________

( ) Info faxed to All Aftercare Providers on (Date)_________________by______

Continuing Care Plan/Discharge Summary

Addressograph

PART I

Please complete this form without acronyms, abbreviations or jargon; the patient should be able to fully understand content in order to follow. An interpreter for Spanish must be provided for Spanish speaking only patients.

Patient Name: _____ Date of Birth: _____/_____/_____

Admitted: _____/_____/_____ Discharged:_____/___/____ Admission # ☐ 1st ☐ 2nd ☐3rd >3 List____

Repeat Admission Status: Check all that apply: ☐ Readmit within 30 Days or Less

☐ 3 or More Admits within Past Year ☐ 10 or More Admits Lifetime

Type of Insurance Benefits: ☐Medicaid ☐Medicare ☐Military/Veteran ☐Private/Other:_____

☐Check if patient identified in CCNC portal. If identified, Care Manager Name _____

Discharged to Address:_____ Ph#:(___)_____

_____ Fax #: (___)_____

Discharged to: ☐*TCLI Private Residence ☐Private Residence (**not** *TCLI) ☐Group Home ☐Adult Care Home

☐Halfway House ☐Skilled Nursing Facility ☐Homeless Shelter ☐Family Care Home ☐Other: _____

Contact Person/Billing Address – Name_____ Relationship: _____

Address: _____ Phone #: (____)_____

Significant Other/Guardian – Name_____ Relationship: _____

Address: _____ Phone #: (____)_____

Designated Payee – Name: _____ Relationship_____

Address: _____ Phone #: (____)_____

*TCLI – Transitions to Community Living Initiative

Discharge Status: ☐ Court-ordered Outpatient Commitment Expiration Date: _____/_____/_____ County _____

☐ SA Outpatient Commitment Expiration Date: ____/_____/_____ County _____ ☐ No Outpatient Commitment

Reason for outpatient commitment: _____

Instructions to Community Providers: How to Prevent Crisis or Calm Patient, Including Relevant Services:

_____

_____

_____

_____

_____

_____

_____

_____

Continuing Care Plan/Discharge Summary Addressograph

PART II: ANTICIPATED PATIENT NEEDS AND REFERRAL LEVELS OF CARE

CONTINUING CARE PROVIDER INFORMATION

TO BE COMPLETED BY SOCIAL WORK STAFF

A. Psychosocial Needs to be Addressed: (Check all that apply)

☐ Access to Health Care	☐ Social Support	☐ Recreation
☐ Cognitive/Judgment Issues	☐ Social Services	☐ Self-Care
☐ Coping Skills	☐ Lack of Transportation	☐ Language Barrier
☐ Significant Medical Concerns	☐ Unemployment	☐ 12-Step Meetings
☐ SSI/SSDI/ Medicaid/Medicare	☐ Cultural/Spiritual	☐ Legal or Juvenile Justice System
☐ Social Skills	☐ Medication Assistance	☐ Financial Stressors
☐ Family/Marital Assistance	☐ Advance Directives	☐ Housing Needed
☐ Public Education	☐ Education Other	☐ Other: _____

Explain all items checked. Please be specific with recommendations for treatment approach for the above checked needs:

_____

_____

_____

_____

_____

_____

_____

B, Type of Service(s) Recommended: ☐ AA ☐NA ☐ Assertive Community Treatment Team (ACTT)

☐ Community Support Team (CST) ☐ Geriatric Specialty Team ☐ ADATC ☐ Home Health

☐ Substance Abuse Intensive Outpatient Program (SAIOP) ☐ Individual Therapy ☐ Peer Support ☐ Substance Abuse Comprehensive Outpatient Treatment (SACOT) ☐ Psychosocial Rehabilitation (PSR) ☐ Multi-systemic Therapy (MST)

☐ Intensive In-Home (IIH) ☐Group Therapy ☐ Psychiatric Residential Treatment Facility ☐ Child & Adolescent Day Treatment

☐ Family Therapy ☐ Physical Rehab ☐ Medication Management and Treatment ☐ County Resource List Provided

☐ NC Care Link Info Provided ☐ National Alliance on Mental Illness (NAMI) phone number: 800 451-9682 ☐ Vocational Rehab

☐ Targeted Case Management ☐ SSI/SSDI Outreach, Access and Recovery (SOAR) ☐ IDD Clinical Home/TCM/Care Coordinator

☐ NC START ☐ Supported Employment ☐ In Reach Housing Resources

☐Other _____

C. Firearms present in the home? Check respondent's answer to question: ☐Yes ☐No

☐If Yes, recommended removal of firearms for safety.

Input into this Plan Received From ☐ Patient ☐ Family ☐ LME/MCO ☐ Hospital Treatment Team ☐ Outpatient Provider ☐ Residential Provider ☐ Other

Hospital Social Worker involved in this Discharge: _____

Signature

_____

Printed Name & Phone Number

LME/MCO Liaison Involved in this Discharge: _____

(Name and Phone Number)

Continuing Care Plan/Discharge Summary Addressograph

PART III: MY RECOVERY PLAN

Name: _____

My Emergency Contact:
Phone Number: _____ **Name:** _____

My LME/MCO Crisis Number _____

What I am like when I am feeling well. Describe what a good day looks like for me and provide examples of how I feel when I have a sense of overall wellness and wellbeing. Describe how I interact, appear, and behave and what meaningful activities I participate in.

Early signs that I am not doing well. Things that may trigger the onset of a crisis, such as anniversaries, holidays, noise, change in routine, medical problems or not getting needs met, need medication(s), being isolated, etc. What do I do when I'm not doing well such as not keeping appointments, isolating myself, communicate loudly/hyper-verbal, etc.

Ways that others can help me, what I can do to help myself. Describe things that help me continue to do well. Examples include: breathing exercises, journaling, taking a walk, etc. Note any individuals to whom I respond best. .

To Prevent Crisis	If I Have a Crisis

What has worked well with me...what has not worked well. Treatments that have and have not worked in past crises; Specific recommendations for interacting with me during a crisis. Describe preferred and non-preferred treatment facilities, medications, etc. Describe how crisis staff should interact with me when entering a crisis. For example, I like music, I like to go for a walk, I like to be talked to, peer counseling, I don't like to be touched, etc.

Continuing Care Plan/Discharge Summary

Addressograph

Part IV (pages 5 and 6) **Medical Diagnoses, Follow Up Recommendations and Education:**

Completed by Medical Provider

Medical Care Follow Up:

☐ No aftercare appointment needed.

☐ Appointment needed with ☐Primary Medical Provider in ☐ _____days/weeks/months &/or ☐as needed for med refills.

☐Specialist in _____days/weeks/months.

☐Other _____in _____ days/weeks/months.

Appointments to be arranged by **(check 1):** ☐Patient ☐Family ☐Social Worker ☐Residential Facility Staff ☐LME/MCO Staff

If PATIENT is to make Appt check one:

☐ Social Worker to provide information regarding medical resources.

☐ Patient has medical provider, needs no further resources at this time.

Diagnoses/Findings/Tests of concern: Instructions/Recommendations for Patient

☐Smoking Causes Cancer/Heart Attack/COPD/Death → **Please QUIT Smoking (NC Tobacco Use Quit Line: 1-800-784-8669)**

☐Asthma/COPD → Get a recheck with Dr in_____

☐Abnormal Cholesterols/Body Fats → Reduce fats and sweets, Get recheck with Dr. in _____
Total chol _____ LDL "bad" chol_____ HDL "good" chol _____ TG _____ ☐Exercise **OR** ☐Discuss Exercise program with your Dr.

☐Elevated Blood Pressure/Hypertension → Get a recheck with Dr. in_____

☐High Blood Sugar, Diabetes, Metabolic Syndrome → Eat a heart healthy diet/ Get a recheck with Dr. in _____

☐Coronary Artery Ds☐Abnormal EKG☐Low/High Heart Rate → Get a recheck with Dr. in _____

☐Overweight/Obese → Eat heart healthy diet/Get a recheck with Dr. in _____

☐Liver abnormality_____ ☐AST ____ ☐ALT_____ → Get a recheck with Dr. in _____

☐Abnormal Blood Count ☐Low☐High

☐Red Cells☐White Cells☐Platelets:Details_____→ Get a recheck with Dr in _____

☐GI: ☐Constipation☐GERD☐Gastritis☐IBS☐IBD → Get a recheck with Dr in _____

☐Seizure(s)/Seizure Disorder _____ → Get a recheck with Dr. in _____

☐Acute☐Chronic Pain _____ → Get a recheck with Dr. in _____

☐Abnormal Thyroid _____ → Get a recheck with Dr. in _____

☐Immunizations given: _____ → Immunizations needed: _____

☒ If you are currently ABLE to become pregnant please contact your health department/private provider for pregnancy prevention or family planning services.

☒ If you GET pregnant, see Dr. for evaluation right away.

☐You are on medication(s) that can harm a fetus. If you get pregnant consult your Dr. right away.

Continuing Care Plan/Discharge Summary Addressograph

Part IV Continued from page 5 - **Medical Diagnoses, Follow Up Recommendations and Education**

Completed by Medical Provider

DIET: ☐Regular ☐Heart Healthy/Diabetic/Calorie Controlled ☐Other
Diet:_____

ALLERGIES: Food, Contact - List_____

ALLERGIES: Medication - List_____

Other Medical Diagnoses and Follow Up/Treatment:

☒ **Take all Medications as prescribed and recommended.** ☒ **Take this document to your Medical Provider at your next visit.**

The information and instructions contained on pages 5 and 6 of this Continuing Care Plan have been explained to me. I acknowledge that I understand the instructions and that a copy of the instructions has been provided to me. I agree to follow the instructions.

Medical Provider Signature for pages 5 and 6:	**Print:**	**Date/Time:**
Signature of staff member giving instructions:	**Print:**	**Date/Time:**
Patient/ Legally Responsible Person Signature:	**Print:**	**Date/Time:**

Continuing Care Plan/Discharge Summary Addressograph

Part V (pages 7 and 8) **ORYX Core Measures Supplemental Data/Medication Information and Instructions**

Completed by Psychiatrist

I have reviewed the Medication Reconciliation form and the current patient medication list to determine the following medications:

Antipsychotic Medications Prescribed at Discharge (check all that apply):

- □ Aripiprazole (Abilify®) □ Abilify® Maintena
- □ Asenapine (Saphris®)
- □ Chlorpromazine (Thorazine®)
- □ Clozapine (Clozaril®, FazaClo®)
- □ Fluphenazine (Permitil®, Prolixin) □ Prolixin® Decanoate
- □ Haloperidol (Haldol®) □ Haldol® Decanoate
- □ Iloperidone (Fanapt®)
- □ Loxapine (Loxitane®)
- □ Lurasidone (Latuda®)
- □ Olanzapine (Zyprexa®) □ Zyprexa® Zydis □ Zyprexa® Relprev
- □ Olanzapine + Fluoxetine (Symbyax®)
- □ Paliperidone (Invega®) □ Invega Sustena®
- □ Perphenazine (Trilafon®)
- □ Pimozide (Orap®)
- □ Quetiapine (Seroquel®)
- □ Risperidone (Risperdal®) □ Risperdal Consta®
- □ Risperidone (Risperdal M-Tab®)
- □ Thioridazine (Mellaril®)
- □ Thiothixene (Navane®)
- □ Trifluoperazine (Stelazine®)
- □ Ziprasidone (Geodon®)

Rationale for prescribing 2 or more antipsychotic medications (Check One):

□ History of minimum of 3 or more failed trials of monotherapy. List 3 failed medications:
(1)_____
(2)_____
(3)_____

□ Recommended plan to taper to monotherapy or tapering in process (cross taper)
Medication being decreased:
_____
Medication being increased (if applicable)
_____

□ Augmentation of Clozapine

□ Other - Specify and explain below:
_____
_____
_____

Cognitive Impairment (entire hospital stay):
□ Yes □ No □ Unknown

Comfort Care:
□ Day 0 or 1 □ Day 2 or After
□ Not Documented/Unknown
□ Not on Comfort Measures
□ Timing Unclear

Reason for Admission: _____
(Print legibly. No abbreviations-All diagnoses must be included.)

Final Principal Diagnosis: _____

Other Discharge Diagnoses:
Behavioral Health Diagnoses (Psych/IDD/SA) _____

Medical Diagnoses:_____

Psychosocial Stressors: _____

Assessment of Functioning Measures: _____

Continuing Care Plan/Discharge Summary Addressograph

Part V Continued from page 7- **ORYX Core Measures Supplemental Data/Medication Information and Instructions**

Completed by Psychiatrist

DISCHARGE MEDICATIONS **DISCHARGE DATE**_____

DRUG ALLERGIES: ☐ None ☐ List_____

***** Please note -** due to the potential for harm, no medications brought to the hospital are being returned except as noted below. Please take medications as directed on your medication containers.

Discharge Medications ☐ **Spanish Labeling**	**Dose/ Route**	**Frequency**	**# of doses to dispense**	***** Return Pre-admission medication to patient**	**Outside Prescription**	**Indication for Medication**
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Patient Instructions:

☐ Follow-up with Mental Health Provider/Private Psychiatrist ☐ Follow-up with Medical Provider

☐Follow all recommendations ☐ If your condition worsens, contact your After Care Provider

☐Medication Education Provided ☐Other:_____

Psychiatrist Signature for pages 7 and 8:	**Print:**	**Date/Time:**
Co-Signature (if applicable)	**Print:**	**Date/Time:**
Signature of staff member giving instructions:	**Print:**	**Date/Time:**

All the instructions contained in this Continuing Care Plan have been explained to me. I acknowledge that I understand and will follow these instructions. A copy of this continuing Care Plan has been given to me.

Patient/ Legally Responsible Person Signature:	**Print:**	**Date/Time:**

Facility Authorization Disclosure Forms must be completed for all needed exchanges of information.